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A CASE OF ACCIDENTAL HEMORRHAGE IN THE FIRST STAGE OF LABOR AT FULL TERM.

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As there is some variance among authors as to the symptoms and treatment of the infrequent condition of accidental hemorrhage in the first stage of labor, I report the following case:

On September 11th, I was urgently called to Mrs. R., a robust woman, aged forty-two, in her fourteenth pregnancy, at full term. I found her in a state of collapse, pulseless at the wrist, the extremities icy cold, with great anxiety and restlessness, complaining of blindness and of continuous pain in the lower abdomen. A hasty examination revealed evidence of only slight external hemorrhage, a dilatable os, and a vertex-presentation with the membranes intact. Blood of a dark color and syrupy consistency, giving the characteristic odor of old blood-clots, clung to the examining finger. The womb was greatly distended and bulging into the abdomen; it was rather tense, but still imparted to the hand an inelastic, boggy feel. There were no movements or other signs of life of the fetus.

I at once informed the nurse that the patient was in a very critical state, and called for assistance. My efforts were directed toward reviving the patient. I lowered the head, applied heat to the extremities, and gave hypodermatically spirit of camphor, morphin and atropin, nitro-glycerin, and alcohol, very freely. In twenty min-

utes I was rewarded by a return of the pulse at the wrist, and in an hour and a half reaction was well established. I adhered to a rule I have always followed in labor, and gave no ergot until the womb was emptied. The question confronted me from the beginning, whether I should delay or attempt immediate delivery. In the collapsed condition of the patient I believed that the slightest additional hemorrhage meant a disastrous end. Further on, when she had rallied, there were no labor-pains, and consequently there was no promise of contraction and retraction of the womb after delivery. Guided only by the condition before me, I determined to temporize and await developments. The pains in the lower abdomen and lumbar region grew worse and continued without intermission. About three hours after I first saw the patient the physician I had sent for arrived, and after emptying the bladder at his suggestion, we ruptured the membranes and thus brought on feeble labor-pains. The parturient canal was roomy and advancement was due mainly to the expulsive efforts of the mother, rather than to the weak contractions of the uterus. Compression was used over the fundus. In three-quarters of an hour a lifeless child was born, and energetic efforts failed to resuscitate it. The placenta was at once taken away, followed by a basinful of clotted blood. The placental site seemed to have been at the fundus, though the placenta was wholly detached when removed. The wound contracted well, we administered a couple of doses of ergot, and the woman proceeded to a good recovery.

Two weeks before confinement the patient had had a violent fall on the buttocks, which was followed several times, at intervals of a few days, by what she termed "sinking spells"—symptoms of internal hemorrhage—occurring usually at night while she was in bed. Traumatism is considered the most fruitful source of accidental hemorrhage before labor, but in a paper by Dr.

Coe, of New York, read before the American Gynecological Society, in 1891, he stated that traumatic injury was the more infrequent origin of hemorrhage during full-term labor, which is the more fatal form.

The readiness with which the circulation regained its volume led me to believe that the collapsed condition was not wholly due to exhaustion from loss of blood, though the hemorrhage was great, as was shown by the débris finally discharged from the womb; it was doubtless in part produced by shock incident to the sudden and extreme over-distention of the uterus. I attributed the absence of labor-pains to loss of contractile power, caused by the abnormal stretching of the uterine muscular fibers.